County of San Diego

HEALTH SERVICES ADVISORY BOARD

1600 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

Thursday, February 16, 2017 | 3:00-5:00 PM
1600 Pacific Highway, Room 302/303

MEETING MINUTES

Members/Alternates Present	Members Absent/Excused	Presenters	HHSA Support
Seat 7/Dist 4 James Lepanto, Chair Seat 8/Dist 4 Kyle Edmonds, Vice Chair Seat 2/Dist 1 Paul Raffer Seat 3/Dist 2 Judith Shaplin Seat 11/Cmty Paul Hegyi Seat 13/Cmty Tracy Garmer (alt) Seat 14/Cmty Greg Knoll Seat 17/Cmty Bob Prath	Seat 1/Dist 1 (vacant) Seat 4/Dist 2 (vacant) Seat 5/Dist 3 (vacant) Seat 6/Dist 3 (vacant) Seat 9/Dist 5 (vacant) Seat 10/Dist 5 (vacant) Seat 12/Cmty Dimitrios Alexiou Seat 13/Cmty Henry Tuttle Seat 15/Cmty Phillip Deming Seat 16/Cmty Leonard Kornreich	Karen Waters-Montijo, Chief, Epidemiology and Immunization Services Branch (EISB)	Saman Yaghmaee, Deputy Director, PHS Wilma Wooten, Public Health Officer Victoria Ollier, Secretary, PHS Admin Kay Collier, Secretary, PHN Admin

Minutes	Lead	Follow-up Actions	Due
		None	

Agenda Item	Discussion
1. Welcome & Introduction	James Lepanto called the meeting to order and welcomed Public Health Services staff in the audience, introducing them to the board: Liz Hernandez, Assistant Director; Karee Hopkins, Nora Bota, and Jamie Schroer Culbert, of the County Childhood Lead Poisoning Prevention Program; and Chris Lee, Lead Program Coordinator for the City of San Diego, contracted to provide support to the County's lead poisoning program.
2. Public Comment	No public comment.
3. Action Items	A. Approval of November 17, 2016 meeting Minutes Greg Knoll motioned to approve; Judith Shaplin seconded. All voted Aye.

Agenda Item	Discussion
3. Action Items (continued)	B. Approval of Board Letters 1. Childhood Lead Poisoning Prevention Program (CLPPP) Presenter: Karen Waters-Montijo, Chief, EISB, Public Health Services This Board Letter will be presented to the Board of Supervisors on 3/21/17, requesting authorization for Clerk of the Board to execute a 3-year revenue agreement with California Department of Public Health (CDPH), totaling $3,839,721 for the period 7/1/17–6/30/20. This request does not offset $20,572 in program expenses during Fiscal Year 2017/18, which will be funded through Health Realignment. <u>Approval</u> Greg Knoll motioned to approve HSAB support of this Board Letter; Judith Shaplin seconded. All voted Aye. <u>Background</u> See **Attachment A, pages 607**. CDPH has funded childhood lead poisoning and prevention related services for the past 23 years. Lead is extremely toxic, accumulated in the body, causing irreversible health problems in even small amounts. All children in publicly supported programs such as WIC are required to be tested at ages one and two years, and physicians assess for testing. If a child tests positive for lead, the State sends a report to the County for follow-up. For years, the County only tracked children who tested at blood lead levels of 14.5 micrograms per deciliter (mcg/dL) or higher. Caseloads doubled in 2004, when this blood lead threshold was lowered to 9.5-14.4 mcg/dL. CLPPP provides the following: Public Health Nurse case management, coordinating with family pediatricians for testing, and helping families to eliminate lead sources, monitoring over time for success; MOAs with the County Department of Environmental Services and City of San Diego for support in home assessments; education for childcare and preschool programs, refugee service organizations, and health care providers; and prevention activities, including screening of children, with a focus on high-risk populations. Hispanic children have been the majority of those who test positively for lead in San Diego, with increases for Asian, white and other populations, such as Middle Eastern refugees. Exposure to lead is through the environment, primarily lead-based paint in housing built prior to 1978. Other sources include dust (remodeling, hobbies like stained glass), dirt, toys, makeup, cooking with pottery containing lead, spices, home remedies and candies. The San Diego water system is safe, tested regularly. In school districts, older water pipes may have lead fittings, although unlike the current alarm of blue water in the San Ysidro School District, water from lead-fitted pipes would be colorless and odorless. New funding from this 3-year CDPH revenue agreement will allow CLPPP to hire a community contractor to assist with home visits of children who test at a lower blood level than 9.5 mcg/dL. Currently, nurses are at capacity with caseloads of 90, and caseloads are also managed longer as of July 2017, due to a change in State definition that requires children age one to be monitored until blood lead levels are below 9.5 mcg/mL. <u>Discussion</u> No discussion.

Agenda Item	Discussion
3. Action Items (continued)	2. Refugee Health Assessment Program (RHAP) - Dr. Wilma Wooten There has been a 30% reduction in funding that was recently approved by HSAB for RHAP--from $2.13 million to $1.49 million. This budget reduction is due to an approximately 50% decrease in the number of refugees permitted into the country nationwide under the new Trump administration. It was projected that 110,000 refugees would enter the U.S. To date, 32,000 have settled, and 12,000 more will be permitted to enter.
4. Updates/ Presentation/ Discussion	A. Immunizations Update- Karen Waters-Montijo Under Senator Richard Pan's leadership, and efforts of Assemblywoman Lorena Gonzalez, legislation was passed to eliminate the Personal Belief Exemption for immunizations in schools. All children are now required to be up-to-date on their immunizations in order to attend public schools. B. Health Services Capacity Plan Task Force Update - Dr. Wilma Wooten The Health Services Capacity Task Force was formed in response to overcrowding in hospitals at the end of 1998 that overburdened Emergency Departments. Because communication was lacking, EMS brought stakeholders together: hospitals, fire departments, ambulances, military, Hospital Association, County Medical Society, and nonprofits like Red Cross, among others. The Task Force has continued to meet annually in August or September to review the Health Services Capacity Plan and to update it. Dr. Wooten disseminates the updated Plan, which consists of 4 levels that will activated as need escalates. Level 1 is continuous at baseline, monitoring surveillance data of patient flow through the ER system. The higher levels are seldom activated to address surge events, such as the influenza outbreak in 2003 when there was a shortage of flu vaccine. The purpose of the Health Services Capacity Plan is to have procedures in place so that ambulances are able to off-load patients to ER staff in a timely manner, which releases them to return to service and fulfill contractual obligation. If ER staff is unable to treat or provide beds for patients being delivered, ambulances will experience service delays in turn. In February 2016, Emergency Department (ED) volumes surged. In San Diego, ED stress occurs if off-loading times increase more than 30 minutes. The Task Force Core Group met weekly to strategize how to address contributing factors and seek solutions related to IT, outreach, education, and surveillance. Metrics were needed to develop operational triggers that could be identified and corrected on the spot at hospitals; real-time access to ambulance delay times were needed; and some trigger thresholds needed to be lowered. An Offload Delay Algorithm was developed as procedures to be followed when a problem is identified. Most ambulance providers purchased First Watch, a web-based data analytics software application, to better understand flow of operations, develop standards through metrics collection, and identify data triggers. PHS expanded its contract with First Watch to include the Transfer of Care (TOC) module, which is now in pilot phase. First Watch is one tool. The Task Force is also studying how to locally implement 7 best practices outlined by Washington State (see **Attachment B, pages 8-9**), such as hospital staff helping to schedule appointments at community clinics for individuals who frequently impact Emergency Departments, especially for mental health problems. Sharp and UCSD health systems are working with Family Health Centers in San Diego to provide small in-patient units near Hospital ERs, following a pattern used in Palm Springs. A tool is already being used that tells what happened in Emergency Departments the day prior. Obtaining real-time data is the next problem to be addressed. The County is working with San Diego Health Connect to find a solution. Hospitals know their most frequent users, but addressing their issues in real time is next.

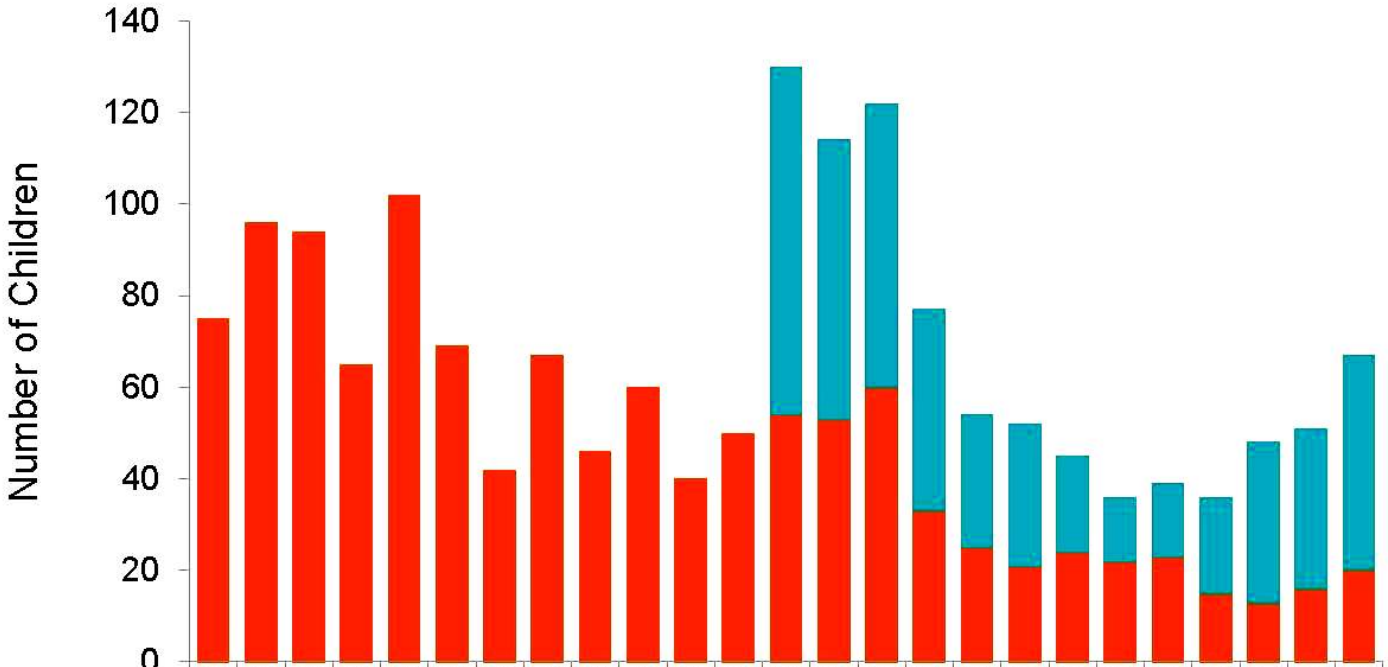
Agenda Item	Discussion
5. Chair's Report	A. Strategic Plan Priority Summary– Dr. Wilma Wooten Dr. Wooten reviewed the 4 Strategic Plan goals, and the objectives that members prioritized under the 6 strategies that align beneath those goals. The following were chosen as highest priority for the current year out of the 30 objectives: ▪ Work with County officials to solicit expectations, aligning priorities to recommendations. ▪ Strengthen the function of board committees. ▪ Seek access to HHSA health services. ▪ Address ACA implementation. ▪ Address lack of access to mental health services. ▪ Advocate strategies for housing. ▪ Solicit input from stakeholders on 2 key issues, focusing on integration, access, and quality. ▪ Provide policy advice to Board of Supervisors. It will take time before substantive changes are made to the ACA by the federal government, but steps are already being taken, such as relaxing IRS reporting. HSAB needs to be flexible in its work on the above selected objectives to provide time to assess the impact of ACA changes, focusing on budget and legislation, and communicating changes effectively to the San Diego community and what the board can do to help.
	B. Board Related Issues - James Lepanto 1. Meeting Time/Day Supervisor Ron Roberts is convening a task force on homelessness, and has requested the current HSAB meeting location at the same date/time for the next two years. The board agreed to keep the same meeting date and time, but move location to the Health Services Complex at 3851 Rosecrans Street. 2. Vacancy There are currently 6 board seats vacant; one has been vacant for over a year. James Lepanto spoke with Agency Director Nick Macchione and Board of Supervisor aides, and hopes to see names recommended within 30 days. He will report back in March.
6. Informational Items	A. Committee Reports See the "Subcommittee Strategy Meeting Brief," **Attachment C, page 10**. Dr. Kyle Edmonds developed a template for the quarterly Committee Reports that will feed into the annual report. Committees will function better once vacancies are filled, and structure and expectations are identified. Each new member will be assigned to one of the 4 Committees: Programs and Policies, Budget, Health Legislation, and Strategic Planning/Annual Report. Policies will need a longer serving member who is knowledgeable, and the board vice chair will need to chair Strategic Planning/Annual Report Committee in preparation for the chair's position.
7. Public Health Officer's Report	Dr. Wooten reviewed items in red text on the Public Health Officer's Report (See **Attachment D, pages 11-13**).

Agenda Item	Discussion
7. Public Health Officer's Report (continued)	During review of the Public Health Officer's Report, there was further discussion on two items: A. Influenza Dr. Wooten provided a handout of the "Influenza Watch," dated 2/11/17. There were 555 new influenza cases and 5 influenza-related deaths reported by 13 hospitals for the week ending 2/11/17. Of the deaths, 96% were over age 65. This is near epidemic level, but Emergency Departments are rebounding. The most current week's "Influenza Watch" can be found online using the web address below: http://www.sandiegocounty.gov/hhsa/programs/phs/documents/InfluenzaWatch.pdf B. Zika Virus Baja California reported its first locally acquired Zika case, so Epidemiology branch is proactively preparing for the possibility that cases may be reported in San Diego this year. They have contacted Miami and the State regarding the kind of public messaging that will be needed, and are working on a Communication Plan. County Department of Environmental Health is putting information into 5 threshold languages, and their website has been updated. The County will receive non-monetary support from CDC, when one outreach worker comes to San Diego in a few weeks to educate and get pregnant women into the registry.
8. Agenda Items for Future Meetings	MAR - *Long Term Care Integration Project,* Aging & Independence Services Medical Care Services Division APR - Diversity & Inclusion [Internal] / Disproportionality Initiatives [external] MAY - Suicide Prevention JUN - Eat Well Standards follow-up presentation
9. Adjournment	This meeting was adjourned at 5:00 PM. Next meeting: March 16, 2017 **New Location**: 3851 Rosecrans Street, San Diego, CA 92110
10. Supplemental Information	A. AIS Long Term Care Integration Project (LTCIP) See **Attachment E, pages 14-15,** for an update from Aging and Independent Services (AIS). B. Eligibility Operations See **Attachment F, page 16**, for the December 2016 update from Healthy San Diego.

ATTACHMENT A – Childhood Lead Poisoning Prevention Program (CLPPP)

NUMBER OF CHILDREN SERVED BY CLPPP

LIVE WELL SAN DIEGO



	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16
BLL 9.5-14.4 ug/dL	-NA-												76	61	62	44	29	31	21	14	16	21	35	35	47
BLL 14.5+ ug/dL	75	96	94	65	10	69	42	67	46	60	40	50	54	53	60	33	25	21	24	22	23	15	13	16	20

- BLL 14.5+ = children with a newly identified confirmed venous BLL 14.5 ug/dL or greater. Total cases since 1992 = 1185.
- BLL 9.5-14.4 = children with a newly identified confirmed venous BLL 9.5 – 14.4 ug/dL. Services to this group began in 2004. Total cases = 492.
- Children under 21 years of age
- Counts are subject to change as additional information becomes available
- San Diego County case counts reflect venous confirmation blood lead levels

Prepared by San Diego County CLPPP, 2/10/2017

ATTACHMENT A – Childhood Lead Poisoning Prevention Program (CLPPP)

Lead-contaminated product recalls can be found on the United States Consumer Product Safety Commission website at https://www.cpsc.gov/en/Recalls/.
Lead-contaminated candies can be found on the California Department of Public Health website at https://www.cdph.ca.gov/data/Documents/fdbLiCLiC07.pdf.

Attachment B

Seven Best Practices Program

ER is for Emergencies

by Jason Busch On Feb 6, 2014

About three years ago lawmakers in Washington state, facing a budget crunch, approached the state Health Care Authority and Department of Health with instructions to cut about $32 million from their budget.

"They came up with the idea of doing that by restricting access to the emergency department," says Stephen Anderson, MD, a past president of the Washington Chapter of American College of Emergency Physicians (WA-ACEP). "If you were on Medicaid, you could only go to the emergency department three times a year.

"Trust me, there were bureaucrats who didn't understand why people in the loop would actually laugh when they heard that. Not only is there HIPAA, which says a prudent layperson always has the right to go to an ED, but it just doesn't make any sense turning away the most vulnerable, the most at risk."

With the help of allied state and national groups, WA-ACEP approached the state to say not only wouldn't its plan work, but it was bad policy. Heads more level prevailed, and what emerged was the Seven Best Practices program, and it's changed the way Washington treats its most at-risk patients.

"The real key was to create an electronic health information exchange that would let us all know right away when anybody checked into an emergency department if they'd been in an emergency department more than five times in the last year," Anderson says. "If they had, that signaled to us they were higher utilizers. It frequently meant they had drug, alcohol and/or psychiatric issues, but it also meant they had cardiac issues, dialysis issues, those types of things. We knew if we were able to coordinate the care of those patients, we'd easily save the state more money than just by telling people not to come to the ED."

Now the highest utilizers of the ED system are identified when they get to the ED and put into a "Patients Requiring Coordination" (PRC) group. The Medicaid system puts together a plan for those patients, both to coordinate a care plan (so if they are going to one hospital particularly often, they'll get assigned to that hospital) and to create a care plan at that hospital and share it will all the other hospitals. The kind of information shared, explains Anderson, can be as simple as "don't re-CAT scan this person for their 20th visit for abdominal pain," but by relaying it between healthcare providers and physicians to prevent redundancy, a lot of time and money can be saved.

Once these high utilizer patients are tied back into a primary care doctor, every ED director in the state gets reports so they can see both how their department is doing and how individual physicians are doing as far as things like identifying patients requiring coordination, trying to decrease the number of narcotic prescriptions going to high utilizers, and trying to decrease x-ray and radiation exposure for the same patients.

In Anderson's opinion the whole thing has been a win for everyone involved. "The docs love it, because of the addition of more tools to help coordinate these patients. It's something they can actually use to help take care of these people," he explains. "The patients like it because you know something about them. 'Oh, you know I already had a CAT scan, what did it show?' And you can tell them, and you won't have to do it again.

"The hospitals had some upfront money to create some of the electronic infrastructure, but they ended up saving money because a lot of the patients were not high-reimbursement patients. And then the bottom line was, the state saw about a 10% decrease across the board in all Medicaid patients and about a 24% decrease across the board in ER visits for the PRC subgroup, and it ended up saving about $33 million, even more than they would've with 'just say no.'"

Attachment B

Washington State 7 Best Practices Program

Seven Best Practices:

1. **Electronic Health Information** – Adoption of an electronic emergency department information system on a statewide basis to create and act on a common, integrated plan of care related to patients with high needs (5 or more visits in a rolling calendar year) by all emergency rooms, payors, mental health clinics, and is sent to primary care providers.

2. **Patient Education** – Dissemination of patient education materials by hospitals and payors to help patients understand and utilize the appropriate resources for care. This would include plans sharing with patients and providers where they can get off hours coverage for primary or urgent care including through nurse call lines and having this information easily available on their web sites.

3. **Identify Frequent Users of the Emergency Department and EMS** – Frequent emergency department (ER) or EMS users are identified as those patients seen or transported to the ER five (5) times within the past 12 months. Hospitals should identify those frequent ER users upon arrival to the emergency department and develop and coordinate case management, including utilization of care plans. Plans, EMS, and mental health clinics will work with patients with five or more visits to identify and overcome core issue which is documented in statewide information system.

4. **Develop Patient Care Plans for Frequent ER Users** – A process to assist frequent ER users with their care plans, such as contacting the primary care provider within 72-96 hours and/or notifying the PCP of an ER visit if no follow-up is required. Payors will provide the information system with the names of the primary care or group for Medicaid patients and provider fax number.

5. **Narcotic Guidelines** – Reduce drug-seeking and drug-dispensing to frequent ER users through implementation of guidelines that incorporate the WA-ACEP guidelines.

6. **Prescription Monitoring** – ER Physician enrollment in the state's Prescription Monitoring Program (PMP). The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances ensuring coordination of prescription drug prescribing practices.

7. **Use of Feedback Information** – Designation of a hospital emergency department physician and hospital staff responsible for reviewing the reports of frequent ER users to ensure interventions are working, including a process of reporting to executive leadership.

Attachment C

HSAB Strategic Planning: Subcommittee Strategy Meeting Brief Summary

Date of meeting: 2/13/17 in Public Health Administration Harbor Room
Summary prepared by: Kyle Edmonds
In attendance: James Lepanto (Chair, HSAB; Budget Subcommittee), Kyle Edmonds (Vice Chair, HSAB), Bob Prath (Health Legislation Subcommittee), Paul Raffer (Policies & Programs Subcommittee)

- Membership
  - HSAB Chair to assign subcommittee chairs
  - Set expectation for all HSAB members to sit on a subcommittee to define a nexus of expertise
  - New appointees will be asked to choose a subcommittee as they on-board
  - Preferable that a relevant content-expert county staffer be assigned to serve as a contact-liaison for each subcommittee
  - Future HSAB membership recruitment can be guided by need for specific subcommittee member expertise
- Subcommittees
  - Programs & Policies: target someone with on-the ground expertise and institutional memory for the Chair role
  - Budget
  - Health Legislation
  - Strategic Planning/Annual Report
    - Rename "Strategy & Innovation"
    - Portfolio to include strategic planning oversight, annual report drafting timeline, annual "advance" planning
    - HSAB Vice Chair to Chair this subcommittee
- Operational & reporting structure
  - Initial meeting should likely occur in person with call-in option but later meetings could be done entirely electronically
  - Monthly meetings with brief minutes forwarded to HSAB Chair/VC/Dr. Wooten/Saman
  - Quarterly reports aligned with County FY presented to HSAB for either information or action depending upon the contents (these reports could be staggered throughout the quarter or presented all at one meeting)
    - 1st Quarter report indicates 3-5 point committee action plan for the year explicitly aligned with HSAB strategic plan
    - 4th Quarter report contains a yearly summary for inclusion in the HSAB Annual Report & review of strategic plan goals & objectives for any necessary updates
  - On-going monitoring of emerging issues for inclusion on HSAB agenda
  - Minutes and quarterly reports would be completed using a standard template
- Other miscellaneous thoughts
  - We could more explicitly offer ourselves to the Board of Supervisions as part of the health-related policy review process
  - Possible for HSAB member shadowing or ride-along half/days with relevant County staff

Attachment D

Public Health Officer's Report

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Health and Human Services Agency
Health Services Advisory Board (HSAB)
Public Health Officer's Report
February 16, 2017 * 3-5PM * 1600 Pacific Highway, SD 92101

I. Communicable Disease Issues

A. Infectious Disease Issues

1. **Influenza – See handout**
2. **Zika Virus**
   - San Diego now has capacity to test for Zika with PCR only (not for IgM and IgG)

Update through 2/10/17:

- **Total Zika Testing referrals to EPI Program for consultation of potential cases: 1099 cases (979 in January), with 892 cases ruled out for Zika.**
- **Confirmed Zika cases (all travel-associated): 82 (82 in January)**
- **Of these, 3 cases from San Diego are in the national Zika Pregnancy Registry**
- **Cases pending lab results or submission: 109 cases pending results.**
- **Travel associated cases:** American Samoa (1), Belize (1), Brazil (2), Caribbean (multiple islands) (1), Central America (1), Columbia (2), Costa Rica (5), Dominican Republic (2), Grenada (1), Guatemala (3), Haiti (1), Jamaica (2), Kiribati (1), Mexico (29), Nicaragua (9), Puerto Rico (3), Saint. Lucia (1), Singapore (1),Trinidad (3), USVI (1), Venezuela (3), and sexual transmission from a traveler (1).
- Again, all reported cases are imported; 0 cases confirmed in pregnant women.
- There are now **25 (24 in February)** Mexican states with documented local Zika transmission, but documented outbreak in Sonora, but NOT in Baja California.
- CDC has created a US Zika Pregnancy Registry for local, state, and territorial health departments
- To date, none of the invasive Aedes species detected have tested positive for Zika.
- Focus in on education and outreach, case reporting, and prevention of mosquito breeding
  - http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/zika_virus.html
  - http://www.sandiegocounty.gov/deh/pests/vector_disease.html

II. Board Actions

A. Getting to Zero is planned for report back to the Board in June 2017, coinciding with National HIV Testing Day

B. Go back to the Board of Supervisors with LEUG on Eat Well Standards on Dec 13, 2016

III. Public Health Issues

A. Activation of Health Services Capacity Plan – **back to Level 1**

1. Core Operational Group continuing to meet on 1st and 3rd Thursdays, as needed.
   - Exploring replication of Washington State Education Campaign with focus on best practices related to:
     - IT
     - Public Education and Outreach (public and physicians)
     - Surveillance and Case Management of Frequent Users
   - Transition of Care (TOC) module from First Watch has been procured by the County. Roll-out being planned.
   - Request presentation on HSAB Agenda in early 2017 (today)

IV. Grants

A. Funded

1. Tobacco program is anticipated to receive over $2.8 million from the state in FY17-18.
2. Additional Tobacco Funding $182K one time only; pending funding from recent legislation
3. Sodium:
   - Partnering with LAHD on new Sodium reduction grant. Local focus: School districts and health care systems. Application submitted last week. $100K/year X 5 years. **AWARDED**

Attachment D

Public Health Officer's Report

4. **SNAP-ED:**
   - **Submitted** next 3-year cycle application and work plan; activities will continue to focus on policy, systems, and environmental change for nutrition and PA
5. **Prevention (Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke):** funded to work in the City of San Diego geographic area
   - **Components**
     1: For implementing food sodium standards and environment and **lifestyle changes** (DPPs) – excited about the development of the Diabetes Prevention Programs
     2: Diabetes prevention and **community clinical linkages**; health system interventions – Chronic Disease Surveillance via EHRs
   - **Summited Year 3 application and work plan on April 30th.**

V. Public Health Initiatives

A. Major Initiatives Updates and Highlight

1) Public Health Accreditation Board –
   a. Annual report due by June 30th
   b. Conducting strategic planning for implementation

2) Branch and Program Fact Sheets – pending

VI. Board Letters Forecast

March 14, 2017		
1. RHAP Augmentation Revenue	TB	Christine Murto
2. Contract for Software Partners	EISB	Karen Waters-Montijo
3. HIV/AIDS: Non-competitive HIV Primary Care Procurement	HSHB	Lauren Brookshire
March 21, 2017		
1. Accept funds from CDPH for Childhood Lead poisoning Prevention Program	EISB	Karen Waters-Montijo
2. Approval of TCRP Bridge Year and next 3-year contract cycle	MCFHS/Tobacco	Irene Linayao-Putman

1. Announcements

a. Personnel - 3 Key Positions
   i. TB, Chief – in interview process
   ii. EMS Chief – in interview process
   iii. Chief Nursing Officer – announcement will be posted soon

2. Site Visits

1/25/2017	Nutrition Education and Obesity Prevention (NEOP) programmatic site visit by Project Officer.	MCFHS - Tina Zenzola
1/31/ 2017 through 2/2/ 17	HRSA: Site visit of Ryan White Part A *(This is Part II of the site visit. Part I occurred on November 2-4 and November 14-17, 2016.)*	HSHB - Patrick Loose
2/1/ 2017 through 2/2/ 17	CDPH: Site visit of Ryan White Part B.	HSHB - Patrick Loose

Attachment D

Public Health Officer's Report

2/25/2017	Nutrition Education and Obesity Prevention (NEOP) programmatic site visit by Project Officer. Two visits are required each federal fiscal year. Project Officer will observe a nutrition education class at Mt. Miguel High School in Spring Valley and visit a Healthy Retail site, Monze Farmer's Market, in La Mesa.	MCFHS - Tina Zenzola

3. **Legislation**
   a. **Tobacco Leg**
   California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) was passed in November2016. It raises the state's tobacco tax by $2 per pack (from $0.87 to $2.87) and directs this funding to tobacco prevention, cures and strengthening a health care system strained by tobacco-related disease. In addition to the $2 per pack tobacco tax on all tobacco products, programs that have received funding via Proposition 99 and Proposition 10 would receive corresponding backfill. Furthermore, this initiative not only includes electronic cigarettes, but corrects previous definitions, to ensure that all tobacco products (e.g., snus) are captured in the State's Other Tobacco Product (OTP) definition and taxed at a rate equivalent to the cigarette tax. Anticipated increased net state revenue of $1 billion to $1.4 billion in 2017-18, with potentially lower annual revenues over time.

4. **HSAB Annual Report – HSAB Chair's Report**

5. **Suggested Future Agenda Items**
   a. Prevention Grant
   b. HIV/AIDS Task Force Recommendations – Getting to Zero
   c. Eat Well Standards

Submitted by Wilma J. Wooten, M.D., M.P.H., Public Health Officer and Director, February 16, 2017

Attachment E

Aging & Independence Services (AIS)

Long Term Care Integration Project (LTCIP)
Update for the Health Services Advisory Board (HSAB)
February 10, 2017

The goal of the Long Term Care Integration Project (LTCIP) is to improve the delivery of health care and long term services and supports for older adults and persons with disabilities. This report includes updates on some key LTCIP activities.

Aging and Disability Resource Connection (ADRC):

Background: The Aging and Disability Resource Connection (ADRC) is a partnership between AIS and Access to Independence. Between the two agencies, the ADRC provides persons of all ages, abilities, and incomes, their caregivers, and service providers with free, comprehensive information about long term services and supports (e.g., personal care, household chores, meals, transportation, home modification, etc.) in San Diego County and delivers care transition support, care management, and options counseling. The ADRC Advisory Committee gives input on community needs and how the ADRC agencies can improve these services.

Update: Members are currently considering various ways to structure our ADRC Advisory Committee meetings in order to make them most meaningful and helpful for guiding the services of the ADRC. Contact Kristen Smith if you are interested in being part of this group. (kristen.smith@sdcounty.ca.gov).

Community-based Care Transitions Program (CCTP):

Background: CCTP was established under Section 3026 of the Affordable Care Act (ACA) in 2011 as a 5-year demonstration to link community based organizations with hospitals to improve care that high-risk Medicare patients receive as they transition across different care settings, reduce the readmission rate for high risk patients and reduce Medicare spending. The San Diego Care Transitions Partnership (SDCTP), a partnership between AIS and Palomar Health, Scripps Health, Sharp HealthCare and the UCSD Health System (13 hospitals) has provided comprehensive, person-centered, health care and social services to over 57,000 high-risk, fee-for-service (FFS) Medicare patients across thirteen participating hospitals since its inception in January 2013. Over the past three years SDCTP has reduced the 30 day, all-cause readmission rate from 21.2% to 10.5% resulting in an estimated $13,793,462 in Medicare savings. The SDCTP's success has resulted in several extensions.

For the final extension period from July 1, 2016 – January 31, 2017, AIS has worked with Palomar Health, Scripps Health, and Sharp HealthCare. The SDCTP continues to work collaboratively to identify ways in which person-centered, coordinated, acute and post-acute care transition services may continue to be delivered to high- risk FFS Medicare patients as well as to other high-risk patient populations across the county after the demonstration project concludes. In the extension period, the program serves approximately 980 patients per month across the three hospitals.

Update: The program enrolled patients until January 31, 2017, and is now following the last group of patients through February. Final participation numbers will be reported in April. AIS and Palomar Health have executed a contract for AIS to serve Palomar patients beyond the CCTP, and has begun to provide services for some patients via this contract. AIS and the hospitals will continue to meet twice a year after the conclusion of CCTP to share best practices regarding Care Transitions.

Coordinated Care Initiative (CCI):

Background: San Diego County is one of seven counties in California selected to implement the Coordinated Care Initiative (CCI), an improved delivery system that provides coordinated health care and long term services and supports (LTSS) to dual eligible and Medi-Cal only beneficiaries in the county. Begun in 2014, CCI consists of two components: 1) mandatory enrollment of dual eligible beneficiaries into managed care for all of their Medi-Cal benefits, including LTSS, and 2) the dual demonstration project, Cal MediConnect (CMC), which provides dual eligible beneficiaries the option of selecting one managed care plan to administer and coordinate both their Medicare (acute medical care and hospitalizations) and Medi-Cal benefits. Those duals who do not choose this option continue to receive fee-for-service

Attachment E
AIS Long Term Care Integration Project (LTCIP)

Medicare. CCI health plans are required to offer four types of LTSS: MSSP, IHSS, adult day healthcare and skilled nursing care. In San Diego County, health plans must partner with AIS for the administration of MSSP and IHSS. CMC health plans may offer other discretionary LTSS known as Care Plan Options (CPO), which include a wide array of a la carte services and support, and also offer transportation and vision benefits. According to the recent enrollment figures published by the Department of Health Care Services (DHCS), there were 14,535 San Diego County duals actively enrolled in Cal MediConnect (CMC) as of January 1, 2017. However, CMC enrollment in San Diego County continues to hold at 33%, meaning that 67% of have either opted-out or have disenrolled from CMC. That said, the opt- out/disenrollment rate from CMC has been slowing over the second half of 2016 and with DHCS' recent implementation a new comprehensive strategy to improve CCI, there may be an avenue to increased, sustainable enrollment.

Update: The Governor's proposed budget and the changes to the CCI were discussed at the quarterly CCI Advisory Committee meeting held on Wednesday, February 1, 2017. The California Department of Finance determined that the CCI program is not cost effective, prompting a process that ceases all statutory provisions related to CCI as of January 1, 2018. This year DHCS will be restructuring parts of the program in an effort to make it cost **effective. While the CCI has been technically "discontinued," most components remain the same and beneficiaries will not experience changes in service. The main changes are the following:**

- The cost of the In-Home Supportive Services program will be removed from the Health Plans' bundled, capitation rates and will be reverted back to prior state-county share of cost arrangements and IHSS will also return to being a fee-for service benefit.
- Although the funding for IHSS will no longer be included in the Medi-Cal managed care capitation rates, the Governor's proposed budget "encourages" Medi-Cal managed care plans and counties to continue "collaborating" on care coordination.
- The seven CCI counties will also regain collective bargaining responsibilities for IHSS workers' wages and benefits.
- The transition of MSSP from community-based providers (i.e., AIS for San Diego County) to the Health Plans that was to be effective as of January 1, 2018, is now being postponed to January 1, 2020.

The Governor and DHCS are committed to improving the coordination of care for dual-eligible individuals and DHCS will continue to work with stakeholders, health plans and providers to make Cal MediConnect a cost effective program that enhances the quality of care.

National Committee on Quality Assurance:

Background: In November 2015, AIS was one of ten organizations chosen from across the United States to participate in the National Committee on Quality Assurance's (NCQA) 18-month long program: Piloting Standards to Support Coordination of Long Term Services and Supports (LTSS) Learning Collaborative. NCQA's new Case Management Accreditation for LTSS is a comprehensive accreditation program dedicated to quality improvement. To prepare for accreditation, AIS has created a standardized training academy for our social workers, and we are developing a data collection tool that is reflective of person-centered care (PCC) work, and we are establishing a Policies and Procedures manual that focuses on person-centered care and NCQA case management standards for LTSS. The timeline for the accreditation process is over 1 year, so we hope to gain accreditation in early 2018. NCQA staff conducted a site visit in October. The purpose of the site visit was for NCQA to evaluate their own process of developing the new standards. Although the NCQA visitors were not the same staff as the future accreditation survey evaluators, they provided very helpful feedback.

Update: AIS has submitted our application for participating in the accreditation survey. We anticipate that period of program file review will be March or April 2017 through September 2017.

Kristen Smith, MPH, Aging Program Administrator
Health & Human Services Agency, Aging & Independence Services (AIS)
Manager of the Long Term Care Integration Project (LTCIP) Kristen.Smith@sdcounty.ca.gov

Attachment F

HEALTH SERVICES ADVISORY BOARD UPDATE – ELIGIBILITY OPERATIONS

HEALTHY SAN DIEGO –FEBRUARY 2017

HEALTHY SAN DIEGO (HSD)

Enrollment
Please see below for December 2016 data.

Managed Care	December 2016
HSD Enrollment	716,866
State Default Rate*	42.9%
San Diego Default Rate*	39.5%

*Data provided by the Department of Health Services' Health Care Options Section (HCO) via COPS-11 Monthly Enrollment summary report.

COUNTY MEDICAL SERVICES (CMS)

Enrollment	December 2015	December 2016
CMS	85	65

Current CMS materials are available on the CMS website.

BOARD LETTERS

N/A